

# TB Treatment/Discharge Plan

2001A-TB-004

This TB treatment plan template is provided to assist in the capture and maintenance of necessary information to ensure successful completion of treatment. The treatment plan should be discussed with the patient and the caregivers. All treatment plans must be consistent with public health regulations and conform to reporting requirements.

Patient Name	Patient Gender	DOB	SSN
Patient Telephone	Body Weight		
Address			
Emergency Contact	Contact Address		Contact Phone
Estimated Date of Completion of Therapy			

  

1. Case reported to the local and state health departments by: \_\_\_\_\_ on (date) \_\_\_\_\_
2. Drugs and dosages prescribed:    ☐ INH \_\_\_\_ mg    ☐ RIF \_\_\_\_ mg    ☐ PZA \_\_\_\_ g    ☐ EMB \_\_\_\_ mg  
☐ SM \_\_\_\_ g    ☐ B-6 \_\_\_\_ mg    ☐ other \_\_\_\_\_    ☐ other \_\_\_\_\_  
To be ingested:    ☐ daily    ☐ 2x weekly    ☐ 3x weekly    ☐ other \_\_\_\_\_
3. The TB Care Physician will be: \_\_\_\_\_  
Next scheduled visit: (date) \_\_\_\_\_
4. The local/state Public Health Case Manager is: \_\_\_\_\_ Phone: \_\_\_\_\_
5. TB-specific patient education and counseling has been done by \_\_\_\_\_ on (date) \_\_\_\_\_
6. Other follow-up caregivers: \_\_\_\_\_  
(name, agency, & phone)
7. TB Treatment will be:    ☐ Directly Observed Therapy (DOT)    ☐ Self-Administered Therapy (SAT)    ☐ DOT and SAT
8. The DOT worker(s) will be:  
Weekdays: \_\_\_\_\_ (Name)    ☐ health dept staff    ☐ family member    ☐ other  
Weekends: \_\_\_\_\_ (Name)    ☐ health dept staff    ☐ family member    ☐ other
9. DOT will be done at \_\_\_\_\_ from \_\_\_\_ am/pm to \_\_\_\_ am/pm on (days) \_\_\_\_\_
10. Isolation Status:    ☐ no isolation    ☐ home isolation    ☐ legal isolation  
Person monitoring isolation : \_\_\_\_\_
11. Person conducting contact investigation : \_\_\_\_\_
12. Identify any therapy adherence obstacles:  
☐ homelessness    ☐ physical disability    ☐ substance abuse (specify) \_\_\_\_\_  
☐ mental disorder    ☐ none    ☐ other \_\_\_\_\_
13. The following are the proposed interventions for obstacles to adherence identified above: \_\_\_\_\_  
\_\_\_\_\_
14. Identify any personal service needs:  
☐ housing assistance    ☐ food/nutrition    ☐ local/state welfare    ☐ child care    ☐ transportation  
☐ drug treatment    ☐ mental health services    ☐ home health services    ☐ employment services    ☐ none  
☐ other \_\_\_\_\_

Referrals for the needs identified above were/will be made to: \_\_\_\_\_ on (date) \_\_\_\_\_  
(name, agency, & phone)

15. Other considerations/comments: \_\_\_\_\_  
\_\_\_\_\_

  

The following individuals have been notified and approve of the above treatment plan:

☐ Attending physician \_\_\_\_\_ date \_\_\_\_\_

☐ Local Health Department \_\_\_\_\_ date \_\_\_\_\_

Patient Signature: I have received instructions from my physician \_\_\_\_\_ date \_\_\_\_\_

☐ Patient elected not to sign Signature (Discharge Planner) \_\_\_\_\_ date \_\_\_\_\_

## Monitoring for Response to Treatment and Adverse Effects

This TB treatment check-list is provided for the treating physician and for the patient's reference. The outline below is merely a suggested monitoring plan for routine, trouble-free cases of active tuberculosis disease. Refer all questions to either the local health department or to the Division of Tuberculosis Control.

<b>Baseline</b>	<p>Clinical evaluation with particular attention to:</p> <ul style="list-style-type: none"> <li>• Co-morbid illnesses and medications</li> <li>• Risk factors for side effects and non adherence</li> <li>• Chest x-ray (or other appropriate radiographs)</li> <li>• HIV testing</li> <li>• Specimens for AFB smear and culture (ideally 3)</li> <li>• Arrange for susceptibility testing</li> <li>• CBC, renal, and liver profile – if abnormalities detected, investigate as appropriate (1)</li> <li>• Other lab tests may be indicated for certain second line drugs</li> <li>• Visual acuity with Snellen chart</li> <li>• Audiogram if prolonged aminoglycoside therapy is contemplated</li> <li>• Current medications: if patients are on other medications with known/suspected drug interaction, evaluation including levels or monitoring of these drugs is warranted</li> <li>• Substance abuse</li> </ul>
<b>1 month</b>	<p>Clinical evaluation with particular attention to:</p> <ul style="list-style-type: none"> <li>• Response to therapy</li> <li>• Tolerance and adherence with therapy</li> <li>• Sputum for AFB smear and culture (1)</li> <li>• Liver transaminases if: <ul style="list-style-type: none"> <li>• Baseline abnormal,</li> <li>• Symptoms of side effects,</li> <li>• Age &gt; 35,</li> <li>• Other known risk factors for drug induced hepatitis.</li> </ul> </li> <li>• Visual acuity with Snellen chart - if ethambutol will be continued</li> <li>• Other laboratory investigations if clinically indicated or on second line drugs</li> </ul>
<b>2 months</b>	<ul style="list-style-type: none"> <li>• Clinical evaluation (as above)</li> <li>• Sputum for AFB smear and culture (1)</li> <li>• Chest x-ray (particularly if culture negative case)</li> <li>• Liver transaminases: if symptoms or other factors as for 1 month visit.</li> <li>• Visual acuity with Snellen chart - if ethambutol will be continued</li> <li>• Other laboratory investigations if clinically indicated or on second line drugs</li> </ul>
<b>3 months</b>	<ul style="list-style-type: none"> <li>• Clinical evaluation</li> <li>• Sputum for AFB smear and culture - if culture at one month was positive (1)</li> <li>• Liver transaminases: if symptoms or other factors as for 1 month visit.</li> <li>• Visual acuity with Snellen chart - if ethambutol will be continued</li> <li>• Other laboratory investigations if clinically indicated or on second line drugs</li> </ul>

<b>4 months</b>	<ul style="list-style-type: none"> <li>• Clinical evaluation</li> <li>• Sputum AFB smear and cultures <ul style="list-style-type: none"> <li>• If 2-months culture positive</li> <li>• And/or 3-months culture positive</li> </ul> </li> <li>• Visual acuity with Snellen chart - if ethambutol will be continued</li> <li>• Liver transaminases and other laboratory investigations prn</li> </ul>
<b>5 months</b>	<ul style="list-style-type: none"> <li>• Clinical evaluation, liver transaminases, and other laboratory tests if needed</li> <li>• Visual acuity with Snellen chart - if ethambutol will be continued</li> </ul>
<b>6 months</b>	<ul style="list-style-type: none"> <li>• Clinical evaluation</li> <li>• Chest x-ray</li> <li>• Visual acuity with Snellen chart - if ethambutol will be continued</li> </ul>
<b>Therapy Follow-up</b>	<ul style="list-style-type: none"> <li>• No specific follow-up is recommended</li> <li>• It is very important to instruct patients to return at any time if symptoms suggestive of (reminiscent of) active TB recur</li> </ul>

Notes:

1. In patients with epidemiologic risk factors, screening for hepatitis B and C is warranted.
2. It is important to demonstrate microbiologic conversion with two consecutive negative sputum cultures.